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No. 95-1594

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

October Term, 1995

BARBARA A. DE BUONO, M.D., in her capacity as New York State Commissioner of Health; KAREN SCHIMKE, in her capacity as New York State Executive Deputy Commissioner of Health; DEPUTY DIRECTOR, Division of Health Care Financing, Office of Health Systems Management, New York State Department of Health,

Petitioners,

against

NYSA-ILA MEDICAL AND CLINICAL LEGAL SERVICES FUND, by its Trustees, JOHN BOWERS, JAMES CAPO, FRANK LONARDO, WILLIAM P. LYNCH, M. BRIAN MAHER, JAMES P. MELIA, GERALD OWENS and PETER VICKERS,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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BRIEF AMICUS CURIAE FOR THE STATES OF CONNECTICUT, et al. IN SUPPORT OF PETITIONERS

The amici curiae states, through their attorneys general, respectfully submit this brief in support of New York's petition for certiorari.

STATEMENT OF INTEREST

Review of the Second Circuit's decision is of critical and immediate importance to all states, particularly those in which ERISA plans own health care facilities. Under the Second Circuit's decision, *NYSA-ILA Medical and Clinical Services Fund v. Axelrod*, 74 F.3d 28 (2d Cir. 1996), state regulation of such facilities will be severely curtailed, if not eliminated entirely. Even states in which ERISA plans do not currently own health care facilities will be significantly affected: if the decision below remains the law, it is only a matter of time before health care facilities reorganize themselves as plan-owned so that they, too, can evade state public health regulation. The amici states urge this Court to grant certiorari and reverse the Second Circuit's decision.

The Second Circuit held that New York's generally applicable "Health Facility Assessment," N.Y. Pub. Health Law § 2807-d (McKinney 1993 & Supp. 1995), consisting of 0.6% of a medical center's gross receipts, is preempted by ERISA[1] solely because it falls, in the present case, directly on an ERISA plan -- that is, there is "no third party between the plan and the tax." 74 F.3d at 30. In the Second Circuit's view, the supposedly "direct" impact of the assessment on plan-owned facilities distinguishes this case from *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 115 S.Ct.

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[1]ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...." 29 U.S.C. § 1144(a) (1988).

1671 (1995) ("*Travelers*"), in which this Court upheld against an ERISA preemption challenge a statutorily-mandated increase in charges for health care services that had an "indirect" effect on plan costs by virtue of the resulting increase in the cost of purchasing health care services.

This distinction is legally unsound and presents serious obstacles to the states in the exercise of their traditional authority over health care. States are responsible for the regulation of all health care facilities, regardless of their form of ownership. If the decision below is left standing, states will be precluded from exercising their customary authority in the health care field over plan-owned health care facilities, because all regulation has inherent costs that will be imposed "directly" on the plan-owned facilities. There is, moreover, no question that, if *NYSA-ILA* is the law, hospitals and other health care facilities will find a way to reorganize themselves as plan-owned facilities in order to evade state regulation. In states like Connecticut, where all hospitals and many other health care facilities are owned by non-profit entities, such institutions will probably be driven out of business. In addition, as discussed *infra*, if ERISA-owned hospitals are exempt from state health care taxes and other generally applicable state taxes, many states are at risk of losing millions of dollars in federal Medicaid funding, which by statute depends on the uniform application of state tax laws to all health care facilities in a given class. If health care facilities owned by ERISA plans are exempt from state taxation, state taxes may not satisfy federal statutory requirements for receiving matching federal funds.

States are responsible for protecting the health and safety of *all* their residents and regulating *all* the health care facilities within their jurisdictions. Their power to regulate public health and safety through laws of general application must not be made to depend on the organizational choices of ERISA plans. Under *NYSA-ILA*, the health care services obtained by participants in

an ERISA plan that elects to provide its services directly will be entirely unregulated by state law. Rather than the states determining how much regulation is necessary to protect the public's health and safety, ERISA plans that operate their own facilities will be dictating to both the states and plan participants the extent to which the state may regulate. ERISA plans must not be afforded an exemption from generally applicable laws. Preemption of any state law that taxes or regulates plan-operated facilities would cripple the states' power to regulate in the area of public health, compromise their ability to participate in Medicaid, and be contrary to effective, rational public policy.

SUMMARY OF ARGUMENT

This Court should grant certiorari in order to clarify as soon as possible whether plan-operated health facilities are exempt from general state regulation. Because the Second Circuit's decision is based not on the nature of the particular assessment at issue but on the supposedly "direct" effect of that assessment on ERISA plans, the holding below casts in doubt virtually any aspect of state law that increases a plan-run facility's costs. The states need this Court to clarify whether they are at risk of losing their traditional power to regulate in the area of public health and safety whenever an ERISA plan directly operates a health care provider. In addition, the states must learn as soon as possible whether they will remain eligible for millions of dollars of matching federal Medicaid funds, which by federal statute are contingent upon states' health care provider taxes being applicable to all providers within a specific class. If ERISA-owned facilities are exempt from otherwise applicable state health care provider taxes, the states' entitlement to matching Medicaid funds is in jeopardy. Congress, too, should learn without delay whether this Court believes that the ERISA preemption clause was truly intended to exempt plan-owned facilities from state

regulation. This Court should take the opportunity to issue an authoritative holding to which Congress may enact a legislative response.

The Second Circuit's decision is in conflict with this Court's decisions in *Travelers* and in *Mackey v. Lanier Collection Agency & Service*, 486 U.S. 825 (1988). In *Travelers*, this Court upheld, against an ERISA preemption challenge, a New York statute imposing surcharges on the hospital bills of all patients with health care coverage from commercial insurers. These charges were presumably passed through to ERISA plans that purchased insurance for their participants. The Court recognized that Congress did not intend that ERISA preempt generally applicable laws in areas of traditional state regulation, and held that "a law operating as an indirect source of merely economic influence" on the decisions of ERISA plans is not preempted. 115 S.Ct. at 1680. In the Second Circuit's view, the supposedly "direct" effect of New York's Health Facility Assessment on a plan-run facility justified a result different from that reached in *Travelers*. But nothing in *Travelers* indicates that the "directness" of a generally applicable state assessment is, without more, a basis for preemption. By contrast, everything in the decision demonstrates that in this Court's view Congress did not intend that general state laws be preempted simply because they increase the costs of an ERISA plan. *Mackey*, on which *Travelers* relied extensively, likewise makes clear, in direct conflict with the decision below, that a generally applicable state statute is not preempted by ERISA, even when it has the effect of directly depleting plan assets.

The Second Circuit's decision also conflicts with the decision in *Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995), *cert. denied*, 116 S.Ct. 1266 (1996), and with the reasoning of the Sixth and Ninth Circuits in decisions upholding generally applicable tax statutes against ERISA preemption challenges. In *Boyle*, the Eighth Circuit upheld a Minnesota statute imposing a 2% tax on

the gross revenues of health care providers, authorizing providers to transfer the cost of the tax to third party contracts for the purchase of health care, and requiring all third party payers to pay the transferred tax. The economic effect of the Minnesota tax is exactly that of the New York assessment, yet the Eighth and Second Circuits reached opposite results. Similarly, the Sixth and Ninth Circuits have upheld neutral, generally applicable taxes that deplete plan assets or deprive plan participants of benefits. *See Retirement Fund Trust of the Plumbing v. Franchise Tax Board*, 909 F.2d 1266 (9th Cir. 1990); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987). The Second Circuit, in its decision in the present case, preempted a similarly neutral and generally applicable state law solely because its economic effect on an ERISA plan was direct. This Court should grant certiorari to resolve this conflict between the circuits.

REASONS FOR GRANTING REVIEW

I. THE DECISION BELOW SIGNIFICANTLY IMPAIRS THE STATES' ABILITY TO REGULATE HEALTH CARE.

The decision below has the potential to change the entire landscape of health care regulation. Plan-operated health care facilities are increasingly common. *See, e.g.*, Robert Kazel, *Onsite Clinic Expected to Cut Delta Comp Tab*, Business Insurance, January 29, 1996, at 6 (Delta Air Lines builds "occupational health clinic" for its employees); Louise Kertesz, *Employers, Insurers Center Attention on Primary Care*, Modern Healthcare, June 19, 1995, at 136 (Noting "the trend toward employer-sponsored clinics"); Jonathan W. Harris, *On-Site Health Clinics*, The Self-Insurer, January, 1995, at 6 ("employer-sponsored care systems have gained in popularity as

employers continue their attempts to control health care costs"); Deborah S. Cowans, *Interest in Employer-Sponsored Clinics Grows*, Business Insurance, February 21, 1994 at 3. The advent of new forms of health care delivery, in which employers contract directly and sometimes exclusively with health care providers, renders the issue of ERISA preemption even more critical to resolve. *See, e.g.,* Robert Pear, *Doctors May Get Leeway to Rival Large Companies,* N.Y. Times, April 8, 1996, at A1; Laura Johannes, *Doctor Networks Campaign to Offer Health Insurance*, Wall St. J., Jan. 8, 1996, at B1. If the Second Circuit's decision goes unreviewed, there is no doubt that ERISA plans will do everything in their power to restructure themselves to avoid the imposition of assessments and other forms of state regulation, thereby hampering the states' ability to ensure the health and safety of their residents who use the services offered by these plans.

The decision below exempts plan-run facilities from a state assessment that all other health care providers must pay. The basis of the decision is not the nature of the New York Health Facilities Assessment but the directness of its impact. There is thus no principled way to limit its application. All state laws and regulations apply "directly" to any ERISA plan that owns a facility. Not only provider taxes, but also property taxes, payroll taxes and sales taxes, all of which increase the costs of operating a facility, are fair game for preemption when plans run health care facilities. Similarly, if plans operate other types of facilities that are subject to state taxation or regulation, such as day care centers, legal clinics or nursing homes, such state laws would also be preempted under the analysis of the court below.

Health care provider taxes are a common means by which states raise revenue.[2] Federal Medicaid law envisions that states

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[2]*See* Ala. Code § 40-26B-21 (1995) (imposing "providers of medical services privilege tax" on nursing facilities); Conn. Gen. Stat. § 12-263(b) (1994) (tax of 11% on "hospital gross earnings of each hospital"); Fla. Stat. § 395.7015 (1995) (imposing 1.5% assessment on annual net operating revenues of certain "health care entities"); Haw. Rev. Stat. § 346E-2 (1995) (taxes of 6% and 4% imposed on "nursing facility income" and "hospital income" respectively); Ill. Comp. Stat. Ann. § 305 ILCS 5/5A-2 (Michie 1996) (assessment of 1.88% of "adjusted gross hospital revenue" of "each hospital provider"); Ky. Rev. Stat. Ann. § 142.303 (Michie 1995)(2.5% tax on gross revenues of providers "for the provision of hospital services"); Me. Rev. Stat. tit. 22, § 391 (1995) (assessment of .15% of hospital's "gross patient service revenues"); Mass. Ann. Laws ch. 118F, § 15 (Law. Co-op. 1995) (hospital assessments calculated by State Department of Medical Security); Minn. Stat. § 295.52 (1995) (2% tax on gross revenues of hospitals and health care providers); Miss. Code Ann. § 43-13-145 (1995) (assessment on nursing homes of two dollars per bed per day); Mo. Rev. Stat. § 208.453 (1994) (hospitals pay "federal reimbursement allowance for the privilege of engaging in the business of providing inpatient health care"); Mont. Code Ann. § 15-60-102 (1995) ($ 2.80 "utilization fee" paid by each "nursing facility" for "each bed day in the facility"); N.H. Rev. Stat. Ann. § 84-A:2 (1994) (tax "at a rate to be established by the legislature each biennium upon the gross patient services revenue of every hospital"); R.I. Gen. Laws § 44-51-3 (1995) (assessment of 3.75% on "gross patient revenue received by every nursing facility"); S.C. Code Ann. § 12-23-810 (1993) (hospital tax based on total expenditures of each hospital as a percentage of total hospital expenditures state-wide); Tenn. Code Ann. § 68-11-216 (1995) (annual nursing home tax of $2,600 per licensed bed per year); Utah Code Ann. § 26-36-105 (1995) (Medicaid Hospital Provider Temporary Assessment imposed on hospitals' "audited gross inpatient revenues"); W.Va. Code Ann. §§ 11-27-9, 11-27-15 (Michie 1995) (health care provider tax of 2.5% of

(continued...)

will impose health care related taxes on various classes of health care provider and then obtain matching federal payments. *See* 42 U.S.C. § 1396b(w)(3)(A)(i) (1995). In order to qualify for matching funds, a state tax must be imposed uniformly on all services within a particular class of provider. *Id.* at 1396b(w)(3) (1995). Under *NYSA-ILA*, however, health care facilities operated by ERISA plans will be exempt from "direct" taxation. If states are prevented from enforcing their health care taxes uniformly, they may not qualify for federal payment under the Medicaid program. Indeed, it is difficult to see how the Second Circuit could have arrived at its holding had it squarely confronted this conflict between its view of ERISA preemption and the federal Medicaid statute, for its decision would have violated the principle of statutory construction that a court must read potentially conflicting statutes "to give effect to each if [it] can do so while preserving their sense and purpose." *Watt v. Alaska*, 451 U.S. 259, 267 (1981).

In addition to health care related taxes, other state laws and regulations that govern health care providers and ensure the health and safety of patients and the general public will, under the Second Circuit's holding, be unenforceable against health care facilities owned by ERISA plans because they too will have a direct impact on such facilities. State licensing laws and the regulations that implement them require health care facilities to meet a wide variety of minimum standards in areas such as

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[2](...continued)
gross receipts on providers of "inpatient hospital services" and "outpatient hospital services"); Wis. Stat. § 50.14 (1994) (assessment on "occupied, licensed beds" of nursing home facilities). In all but four of these states, the provider taxes are structured to enable the states to obtain matching federal funds. *See* Department of Health and Human Services Reports of Provider Related Donations and Health Care Related Taxes Received for Quarters Ending September 30, 1995 and June 30, 1995.

staff-patient ratios and infection-control practices. *See, e.g.*, Ariz. Rev. Stat. Ann. §§ 36-422--36-425 (1993 & Supp. 1995); Conn. Gen. Stat. §§ 19a-490--496 (1994); Ill. Comp. Stat. Ann. § 210 ILCS 85/1--85/16 (Michie 1996) (Hospital Licensing Act); N.J. Stat. Ann. § 26:2H-12 (1994). States also impose strict standards concerning the disposal of medical waste to protect both patients and the general public. *See, e.g.*, Cal. Health & Safety Code §§ 117600--118360 (Deering 1995); Fla. Stat. § 381.0098 (1995); Okla. Stat. Ann. tit. 27A, § 2-10-308 (West Supp. 1996); R.I. Gen. Laws § 23-19.12-1--19 (1995).

Similarly, states invariably regulate the facilities in which child day care is offered and demand that the people who offer such care meet certain qualifications. *See, e.g.*, Conn. Gen. Stat. § 19a-80 (1995) (requiring licensing of day care centers); Conn. Agencies Regs. §§ 19a-79-1a--12 (1993) (setting forth personnel and facility requirements for license); N.Y. Soc. Serv. Law § 390 (McKinney 1995) (authorizing Commissioner of Social Services to promulgate rules governing licensure of day care facilities); N.Y. Comp. Codes R. & Regs. tit. 18, §§ 418.1 -- 418.20 (1995) (setting forth requirements). And states closely regulate the practice of law. *See, e.g.*, Conn. Gen. Stat. §§ 51-80--88 (1995) (setting forth requirements for practitioners); N.Y. Jud. Law § 90 (McKinney 1995) (authorizing state appellate courts to establish rules of practice); N.Y. Comp. Codes R. & Regs. tit. 22, Parts 603, 691, 806, 1022 (1995) (regulations governing practice). Under the Second Circuit's holding, however, whenever an ERISA plan operates a day care center or a legal clinic, any regulations that increase the plan's costs affect it directly and are therefore preempted.

If it is within ERISA plans' power to avoid the costs imposed by ordinary state regulation, they will surely undertake whatever reorganization enables them to do so. States will be powerless to regulate in areas in which they have traditionally had full regulatory authority--a result that Congress, in enacting the

ERISA preemption statute, cannot possibly have contemplated. Congress's intent is the "ultimate touchstone" of ERISA preemption. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 [1978]). Congress should have the opportunity to understand fully the ramifications of the present case and to consider whether it is necessary to amend ERISA, as it did in 1982 to override a 1981 decision of this Court preempting Hawaii law. *See Retirement Fund Trust of the Plumbing*, 909 F.2d at 1277. In a matter of such immediate consequence, this Court should not await further conflicts and confusion, but should act at once to clarify the law.

II. THE DECISION BELOW CONFLICTS WITH THIS COURT'S DECISIONS IN *TRAVELERS* AND *MACKEY*.

When this Court vacated the Second Circuit's original decision in the present case and remanded the case for further consideration in light of *Travelers*, *see* 115 S.Ct. 1819 (1995), it confirmed what *Mackey* established: A generally applicable state statute that produces an economic effect on ERISA plans is not, for that reason alone, preempted by ERISA. The Second Circuit, misapprehending *Travelers*, believed that the "directness" of such an effect distinguished New York's Health Facility Assessment from the surcharges at issue in *Travelers*. This conclusion, however, rests on a misreading of *Travelers*, which does not make the directness of a state law's impact dispositive for ERISA preemption purposes. The resulting conflict between *Travelers* and the present case warrants review by this Court.

At issue in *Travelers* was a New York statute requiring hospitals to collect surcharges on the hospital bills of patients with health care coverage from a commercial insurer, but not on the bills of patients insured by Blue Cross/Blue Shield. This

Court reversed a decision of the Second Circuit, which had held that this statute was preempted by ERISA. "The basic thrust of the [ERISA] pre-emption clause," the unanimous Court noted, "was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." 115 S.Ct. at 1677-78. This understanding of the purpose of ERISA preemption meant that the statute at issue in *Travelers* was not preempted. Because this statute affected only "choices made by insurance buyers, including ERISA plans," it did not "bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself" or "preclude uniform administrative practice or the provision of a uniform interstate benefit package." *Id.* at 1679.

The Court emphasized that generally applicable laws in traditional areas of state regulation are not preempted simply because of their economic effect on ERISA plans. Thus, for example, "[q]uality control and workplace regulation" in hospitals have the effect of increasing health care costs and thus insurance costs, but do not amount to the " 'conflicting directives' from which Congress meant to insulate ERISA plans." *Id.* at 1679-80. The Court found this conclusion "confirmed by [its] decision" in *Mackey*, in which a general state garnishment statute, applied to a plan participant's benefits in the hands of an ERISA plan, "impose[d] administrative costs and burdens upon benefit plans" but was not preempted. *Travelers*, 115 S.Ct. 1680. "Any conclusion other than the one we draw," the Court observed, "would bar any state regulation of hospital costs," which, as "interference with the hospital services market, would fall on a theory that all laws with economic effects on ERISA plans are pre-empted." The surcharges at issue in *Travelers* affected only "the relative prices of insurance policies," and were thus "no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate," *id.* at 1683; *see also id.* at

1680 (Nothing in language or legislative history of ERISA "indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern").

The decision in *Travelers* leaves no room for ERISA preemption of a generally applicable state assessment on the gross receipts of health care providers, even when a provider is operated directly by an ERISA plan. The Court emphasized that traditional areas of state regulation--including generally applicable state charges that increase the costs of doing business for hospitals and/or insurers--are not preempted simply because of their economic effect on ERISA plans.

Similarly, the Court stressed that a statute with an economic effect on ERISA plans is not preempted unless it has a coercive or preclusive effect on plans' administrative practices, and distinguished carefully between a state statute that merely "affect[s] insurance prices and plan costs" and one that "impose[s] a substantive mandate" on plans. *Id.* at 1681. This reasoning can be and should have been applied to the present case, in which the Health Facilities Assessment, like the surcharge at issue in *Travelers,* does not bind plan administrators to a particular choice or method of operation, but instead merely operates in an area of traditional and general state regulation to increase plans' costs of doing business.

Indeed, if the plan in the present case had operated in the more usual fashion and reimbursed outside health care providers for medical services provided to plan participants, the case would be identical to *Travelers* in every respect. It is only because NYSA-ILA has chosen to operate its own medical center that the factual circumstances of the cases differ at all. But nothing in ERISA or in *Travelers* supports the conclusion that a generally applicable state statute that has the effect of increasing costs to ERISA plans is somehow invalid when, and only when, an ERISA plan operates the entity subject to state

regulation. The Second Circuit itself, in two post-*Travelers* decisions, rejected such an approach, observing that "in the wake of *Travelers* (and the Court's decision to vacate *NYSA-ILA)*, we question whether we should continue to distinguish between laws that directly deplete ERISA plans' assets and laws that only indirectly do so." *New England Health Care Employees Union, District 1199 v. Mount Sinai Hospital*, 65 F.3d 1024, 1032 (2d Cir. 1995); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 63 F.3d 90, 94 (2d Cir. 1995) (holding that surcharges apply to self-insured plans as well as those that purchase insurance).

Unfortunately, the Second Circuit did not take its own counsel in the present case, and thus produced the conflict with *Travelers* that now must be resolved. In *Travelers*, this Court found the notion that ERISA preempts all state laws affecting "the hospital services market" to be "unsettling" and "startling." 115 S.Ct. at 1681. The same adjectives can be applied to the principle that an unquestionably valid state tax on health care providers that would otherwise be passed through to ERISA plans suddenly becomes invalid when it is imposed "directly" on a plan-run facility. It is in order to correct this baseless conclusion that this Court should grant certiorari.

The decision below likewise conflicts with *Mackey*, on which the *Travelers* Court extensively relied. In *Mackey*, the Court upheld a state's general garnishment law that applied directly to the assets of an ERISA plan and imposed substantial administrative costs on the plan. This Court concluded that "Congress did not intend to forbid the use of state-law mechanisms of executing judgments against ERISA welfare benefit plans, *even when the mechanisms prevent plan participants from receiving their benefits.*" 486 U.S. at 831-32 (emphasis added). In *Mackey*, as in the present case, a generally applicable state law directly depleted plan assets that would otherwise have been available

for the use of participants.[3] Like *Travelers*, it cannot be squared with the decision below.

A different aspect of the holding in *Mackey* further establishes the need for this Court's review of the decision below. In concluding that a state statute specifically barring garnishment of plan benefits is preempted by ERISA, this Court observed that "any state law which singles out ERISA plans, by express reference, for special treatment is pre-empted," even when that special treatment is favorable to plans. 486 U.S. at 838. Thus, a state that wanted to exempt ERISA plans from generally applicable regulations could not do so directly. Yet according to the Second Circuit, New York has achieved precisely that result circuitously, by enacting a general statute applying "directly" to ERISA plans and thus automatically subject to preemption. This fundamental paradox, like the clear conflict between the holding below and those in *Travelers* and *Mackey*, indicates that this Court should grant review in order to align these otherwise incompatible decisions.

III. THE SECOND CIRCUIT'S DECISION CONFLICTS WITH THE DECISION OF THE EIGHTH CIRCUIT IN *BOYLE v. ANDERSON* AND WITH OTHER DECISIONS OF THE COURTS OF APPEALS.

The Second Circuit's decision cannot be reconciled with either the decision of the Eighth Circuit in *Boyle v. Anderson* or decisions of the Sixth and Ninth Circuits sustaining generally applicable state taxes against ERISA preemption challenges.

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[3] *Mackey* cannot be distinguished from the present case on the ground that it involved benefits payable to the particular plan participant whose assets were being garnisheed, for the Court noted that in the ERISA statute "no distinction is made between plan funds generally and those funds due a particular participant at a particular time." 486 U.S. at 835.

Boyle upheld, against an ERISA preemption challenge, a Minnesota statute imposing a 2% tax on the gross revenues of hospitals and other health care providers, Minn. Stat. § 295.52 (1995). If providers "transfer additional expenses generated by" the tax "on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer," then "[a]ll third-party purchasers of health care services...must pay the transferred expense in addition to any payments due under existing or future contracts" with a health care provider. *Id.* § 295.582 (1995). The workings on ERISA plans of Minnesota's provider tax are indistinguishable from the operation of New York's Health Facility Assessment on the present plaintiffs, yet the outcomes of *Boyle* and the present case are diametrically opposed. This Court should grant certiorari to resolve the conflict.

The plaintiffs in *Boyle* contended that ERISA preempted the "passthrough" to their plans of any portion of Minnesota's gross receipts tax. They asserted, among other things, that the tax amounted to a mandate directly regulating the terms of ERISA plans and that the economic impact of the tax on plans was itself sufficient for a finding of preemption. Relying both on the multi-factor analysis of ERISA preemption it had adopted in *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341 (8th Cir. 1991), and extensively on *Travelers*, the Eighth Circuit rejected plaintiffs' argument and concluded that none of the factors it considered weighed in favor of preemption. The generally applicable provider tax, which affected all health care providers and all third-party purchasers, did not "negat[e] a plan provision or relat[e] to other ERISA statutory provisions." *Boyle*, 68 F.3d at 1101-1102. It did not "result in any alteration in the authority of the primary ERISA entities" or "impose an administrative burden" on ERISA plans. *Id.* at 1102-1105. Rather, the passthrough did no more than "cause

the plans to pay a slightly increased fee for health care services already covered under the plans." *Id.* at 1103.

Nor was the economic impact of the tax sufficient to warrant preemption under ERISA. The court equated the required passthrough of the provider tax to third-party payers with the passthrough of other costs resulting from state laws that increase health care charges:"[H]ospitals pass through to third party payers such costs as those involved in disposal of hazardous chemicals, compliance with state OSHA standards; hospitals also pass on in their charges state unemployment compensation taxes, payroll taxes, and property taxes." *Id.* at 1107.

Like the 2% Minnesota provider tax, the New York assessment is imposed on the gross receipts of health care providers, albeit at a substantially lower rate. As with the Minnesota tax, health care providers in New York pass the cost of the assessment on to third-party purchasers of health care services, including ERISA plans. In both states, a statute establishes a generally applicable assessment and envisions that its costs will ultimately be borne by benefit plans and their contributors. The workings of the two taxes are indistinguishable, yet the Eighth and Second Circuits reached opposite results on the preemption question.

Respondents will undoubtedly contend that the difference between *Boyle* and the present case is that the present plaintiff is itself a health care provider and suffers a direct economic effect rather than the indirect effect felt by the plans in *Boyle*. As the Second Circuit conceived it, the ERISA plan in the present case *is* the medical center, and the costs of the provider tax (and all the other state-imposed costs of operating a health care facility enumerated by the Eighth Circuit) are not passed through but are direct. This distinction, however, even if it exists, is one without a difference.

First, it is not at all clear that the tax in *NYSA-ILA* is direct. The Second Circuit's holding overlooks the fact that the medical

centers responsible for paying the assessment and the ERISA plan on which the tax supposedly falls are separate entities. Each of the medical centers is separately incorporated as a New York not-for-profit corporation, to which the ERISA plan periodically transfers money to defray operating expenses. The assessment is imposed, not on the ERISA plan, but on the income of the separately incorporated medical centers. Thus, as in *Boyle*, the tax is imposed initially on the separate entity of the health care provider, and affects the ERISA plan only subsequently and indirectly.

Moreover, even if the Second Circuit's characterization of the assessment as falling "directly" on the ERISA plan is accepted, the present case conflicts with *Boyle* because in both cases the ERISA plans are legally obligated to pay the taxes. The plaintiffs in *Boyle* were required by statute to "pay the transferred expense" generated by the provider tax and passed through by providers "on to all third-party contracts for the purchase of health care services on behalf of a patient or consumer." Minn. Stat. § 295.582. In the present case, because an ERISA plan chose to own a medical center, it was obligated to pay a general tax on health care providers. In both New York and Minnesota, the assets of ERISA plans will be "depleted" by virtue of a state assessment on the gross receipts of health care facilities. The only difference is that, in Minnesota, one additional level of billing must occur before the ERISA plan feels the effects of the tax. But this cannot be the basis of a principled or meaningful distinction between the cases. The conflict between *Boyle* and the case at bar is inescapable.

In addition to its direct conflict with *Boyle*, the Second Circuit's decision also conflicts with decisions of the Sixth and Ninth Circuits authorizing the application of general tax statutes directly upon the assets of ERISA plans. Thus, in *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987), the Sixth Circuit upheld a generally applicable 2% municipal tax on

income, even when that income was contributed by employees to their ERISA benefit plans. The tax did not violate ERISA because it constituted a traditional exercise of state authority and because it "affect[ed] Firestone employees in their capacity as employees, without regard to their status as participants in an ERISA plan." *Id.* at 555-56; *see also Thiokol Corp. v. Roberts*, 76 F.3d 751 (6th Cir. 1996) (following *Firestone* in upholding value-added tax on businesses even though tax included employers' payments to employees' benefit plans in calculating employee compensation for purposes of determining value added). New York's Health Facility Assessment operates in like fashion, incidentally affecting the ERISA plan only in its capacity as a health care facility and without regard to its status as an ERISA plan.

Similarly, in *Retirement Fund Trust of the Plumbing v. Franchise Tax Board*, 909 F.2d 1266 (9th Cir. 1990), the Ninth Circuit upheld against an ERISA preemption challenge certain general California tax levy and withholding procedures as applied to ERISA benefits owed to employees. The plaintiff trusts contended that such state procedures "dissipate" plan funds accumulated for plan participants' future use. *Id.* at 1282. Because, the Ninth Circuit said, the underlying tax at issue was valid, procedures to withhold or levy the tax were valid as well. *Id.* Expressly "agree[ing] with the Sixth Circuit's analysis" in *Firestone*, the Ninth Circuit noted that "Congress has preempted only state tax laws that 'relate to' ERISA plans," rather than all state tax laws that have an economic effect on plans but do not interfere with the calculation of benefits. *Id.* at 1281-82. New York's Health Facility Assessment is a similar tax.

The assessment at issue in the present case, like the taxes involved in *Boyle*, *Firestone*, and *Retirement Fund*, is entirely neutral, applying to all hospitals and health care providers in New York, not just to those operated by ERISA plans. Yet in the Second Circuit's view, a neutral, generally applicable

assessment that falls directly on the receipts of a plan-operated health facility merely by virtue of a plan's decision to structure benefits in a particular manner is preempted. There is no way to reconcile these decisions. Only this Court can definitively resolve the conflict between the circuits on this issue, and should grant New York's petition for certiorari in order to do so.

CONCLUSION

FOR THE FOREGOING REASONS, THE PETITION FOR CERTIORARI SHOULD BE GRANTED.

Dated:

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